Welcome
To our office

About you

Today's date:_____

Name:_____ circle one Male Female

What do you prefer to be called? Example: Robert (Bob) _____

Birthdate:_____Age: _____ SS#: _____

Home Address: _____ City:_____State:_____ Zip____

Circle one: Single Married Divorced Widowed Separated

Home Phone: ____-_____ Cell Phone: _____-_____

Work Phone: ____-_____ Employer: _____

Employer's Address: _____

How long worked there? _____ Occupation: _____

Whom may we thank for referring you? _____

Other family member seen by us: _____

Previous Dentist: _____ Last visit date: _____

Spouse Information

His/Her name:_____ Employer: _____

Work phone:____-_____ Birthdate: _____

Medical History

Do you have a personal physician? Yes No

Physician's name: _____ Phone #: _____-_____

Your current physical health is: Good Fair Poor

Explain: _____ Are you taking prescription/over the counter drugs? Yes No List each: _____

Do you smoke or use tobacco in any other form? Yes No

Are you taking any medications at this time? What? _____

Have you ever had any of the following diseases or medical problems? (Please circle)

Abnormal Bleeding Arthritis Anemia

Cancer/Chemo treatments Congenital Heart Defect Diabetes

Difficulty Breathing Epilepsy Fainting Spells

Glaucoma Heart Attack Heart Murmur Heart Surgery

Hemophilia Hepatitis High Blood Pressure

HIV+/AIDS Hip or Knee replacement/pins/screws/plates

Kidney or Liver problems Mitro Valve Prolapse Pacemaker Radiation Treatment

Rheumatic/Scarlet Fever Seizures Artificial Bones/joints/valves

Hospitalized for any reason? Why? _____

Are you allergic to any of the following?

Aspirin Codeine Dental Anesthetics Erythromycin

Metals Jewelry Cinnamon Peppermint Latex

Penicillin Tetracycline

Please list any other drugs that you are allergic to: _____

Dental History

Why have you come to the dentist today? _____
Do you need to be pre medicated before dental treatment? Yes No
Are you currently in pain? Yes No
Have you ever had a serious/difficult problem associated with any previous dental work? Yes No
Do you now or have you ever experienced pain/discomfort in your jaw joint (TMJ)?
Yes No
Your current dental health is: Good Fair Poor
Do your gums ever bleed? Yes No
How many times a week do you floss? _____ a day do you brush? _____

Dental Insurance Coverage

Primary

Insured's Name: _____*Insured's birthdate*_____
*Insured's SS#*_____ Relationship: _____
*Insured's employer*_____
Insurance Co. Name: _____
Insurance Co. Address: _____
Insurance Co. Phone: _____Group # :_____

Secondary

Insured's Name: _____Insured's birthdate: _____
Insured's SS#:_____ Relationship: _____
Insured's Employer:_____
Insurance Co. Name: _____
Insurance Co. Address: _____
Insurance Co. Phone #: _____ Group #: _____
In the event of an emergency, is there someone who lives near you that we should contact?
Name: _____Relation: _____
Work #: _____Home #: _____

Payment Policy

Payment for each visit is requested as services are rendered. Our office will accept cash, check or Mastercard, Discover or Visa Card. If you have dental insurance, we will wait for the insurance to pay us for cleanings, examinations, and x-rays. For other services such as fillings, crowns, bridges, dentures and partials, we will ask for a percentage of the charges the day services are rendered. After the insurance has paid their percentage, we will bill the remaining balance to you. In case of overpayment, we will reimburse you. If you have a secondary insurance we will send this in for you. **ATTENTION:** with our computer program we cannot bill two accounts for families of divorce. If you are responsible to pay a certain amount please do so at the visit and tell the other party to pay the remainder. We cannot be responsible to bill both parties involved. Whichever of the parents bring in the child/children is responsible to make payment arrangements at the time of appointment. If for some reason you cannot make prompt payment, please discuss the matter with the office staff before services are rendered so that a payment plan can be arranged for you.

I understand that the information that I have given today is correct to the best of my knowledge. I will inform your office of any medical history changes. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

Signature: _____ Date: _____